

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																								
CERTIFICATE OF DEATH																								
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>																			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural White Hall</b>					c. LENGTH OF STAY IN 1b <b>37 years</b>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural White Hall</b>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Shawsville</b>					d. STREET ADDRESS <b>Shawsville</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) First <b>NOLA</b> Middle <b>RAY</b> Last <b>ADAMS</b>					4. DATE OF DEATH Month <b>Nov</b> Day <b>16</b> Year <b>1967</b>																			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/19/1909</b>		9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore County, Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Lester W. Copenhaver</b>					14. MOTHER'S MAIDEN NAME <b>Viola Grimm</b>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>213-38-8289</b>					17. INFORMANT <b>C. Merediethe Adams</b>					Address <b>Parkton, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>21120</b>										INTERVAL BETWEEN ONSET AND DEATH <b>21120</b>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <b>1970</b> to <b>Nov. 16, 1967</b> , that (I, (we) last saw the deceased alive on <b>Nov. 15, 1967</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above.																								
22a. SIGNATURE <b>A.M. France</b>										ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22b. DATE SIGNED <b>11/16/1967</b>									
22c. PHYSICIAN'S NAME (Type) <b>A.M. FRANCE</b>										22d. ADDRESS <b>PARKTON, Md.</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					23b. DATE THEREOF <b>11/18/1967</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>					23d. LOCATION (City, town or county) (State) <b>Madonna, Maryland</b>									
24. FUNERAL DIRECTOR <b>Charles E. Kurtz</b>										ADDRESS <b>Jarrettsville, Md.</b>					25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

21084

4571

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

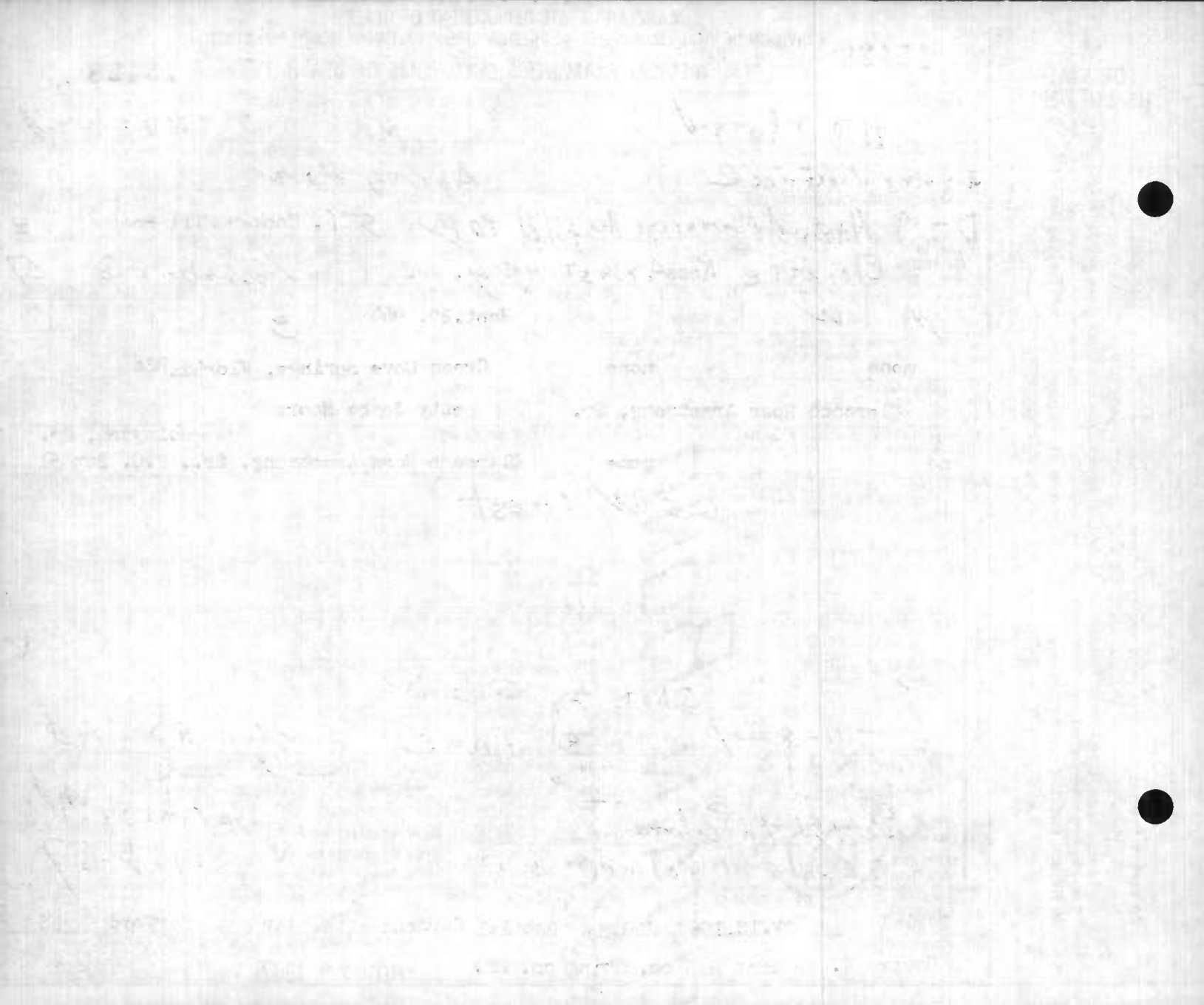
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Hd 2-50-2-d</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DoA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>P.O. Box 51, Hooker Mill Road</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence Ross Armstrong, Jr.</u>		4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 20, 1964</u>
9. AGE (In years last birthday) yrs. <u>3</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Green Cove Springs, Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Ross Armstrong, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Betty Joyce Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Clarence Ross Armstrong, Sr., P.O. Box 51</u>		Address <u>Abingdon, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>9190</u> IMMEDIATE CAUSE (a) <u>G.S.W. chest</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by Sister</u>	
20c. TIME OF INJURY Month, Day, Year <u>6</u> Hour <u>11-8</u> p.m. <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Abingdon Hd Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air Md.	
EXAMINER'S NAME (Type) <u>Gerald P. Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-8-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 10, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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VR A15 (4)  
20 M 1/66

15430

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15429

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>RURAL-COLORA</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth F</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/22/1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE (In years last birthday) <u>70</u> yrs.
13. FATHER'S NAME <u>Andrew Hogus</u>		14. MOTHER'S MAIDEN NAME <u>MINERVA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-01-7963D</u>	
17. INFORMANT <u>Ralph Baughman</u>		Address <u>Harre de Grace, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Extensive Anterior Myocardial Infarction</u> DUE TO <u>Coronary Thrombosis</u> DUE TO <u>A.S. C.V.D.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>2-3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Anuria + Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> , 19 <u>67</u> , to <u>11-26</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>11-26</u> , 19 <u>67</u> , and that death occurred at <u>6:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>11/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre de Grace, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>11/30/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WEST NOTTINGHAM CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>COLORA CECIL MD</u>
24. FUNERAL DIRECTOR <u>RALPH M. REED</u> ADDRESS <u>RISING SUN, MD.</u>		25a. REC'D BY REGISTRAR <u>NOV 28 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

12418

GRAND JURY OF DEATH

A FUGITIVE FROM THE LAWS OF  
THE STATE OF NEW YORK  
AND OF THE UNITED STATES  
OF AMERICA  
AND OF THE DISTRICT OF COLUMBIA  
AND OF THE TERRITORY OF ARIZONA  
AND OF THE TERRITORY OF NEW MEXICO  
AND OF THE TERRITORY OF UTAH  
AND OF THE TERRITORY OF IDAHO  
AND OF THE TERRITORY OF MONTANA  
AND OF THE TERRITORY OF WYOMING  
AND OF THE TERRITORY OF COLORADO  
AND OF THE TERRITORY OF NEVADA  
AND OF THE TERRITORY OF CALIFORNIA  
AND OF THE TERRITORY OF ARIZONA  
AND OF THE TERRITORY OF NEW MEXICO  
AND OF THE TERRITORY OF UTAH  
AND OF THE TERRITORY OF IDAHO  
AND OF THE TERRITORY OF MONTANA  
AND OF THE TERRITORY OF WYOMING  
AND OF THE TERRITORY OF COLORADO  
AND OF THE TERRITORY OF NEVADA  
AND OF THE TERRITORY OF CALIFORNIA



FOR STATE HEALTH DEPT.

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VR A15ME 15  
6M 1/66

15431

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15430

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa - Rural</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Joppa - Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>				d. STREET ADDRESS <b>Box 412, Dembytown Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>C.</b> Last <b>BOND, JR.</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>12</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 29, 1967</b>		9. AGE (In years last birthday) yrs. <b>1</b> Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Robert C. Bond, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Gloria Elder</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Robert C. Bond, Sr. Box 412, Dembytown Road</b>				Address <b>Joppa, Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7562</b> IMMEDIATE CAUSE (a) <b>Convergent Malformation, Intestinal Tract. S.D.I.I.</b> DUE TO (b) <b>Tract. S.D.I.I.</b> DUE TO (c) <b>Tract. S.D.I.I.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Gerald C. Palmer</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Gerald C. Palmer</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				Address (Street, city, town, or county) <b>Bel Air, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 13, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Benezer Baptist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Joppa Harford Md</b>		
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

75019419

The first part of the paper is devoted to a discussion of the  
 general principles of the theory of the structure of the  
 crystal lattice. It is shown that the structure of the  
 crystal lattice is determined by the balance of the  
 forces of attraction and repulsion between the atoms.  
 The forces of attraction are due to the electrostatic  
 interaction between the positive and negative ions, while  
 the forces of repulsion are due to the overlap of the  
 electron shells of the atoms. The balance of these  
 forces determines the equilibrium distance between the  
 atoms, which is the lattice constant. The lattice  
 constant is a function of the temperature and the  
 pressure. The lattice constant increases with increasing  
 temperature and decreasing pressure. The lattice  
 constant is also a function of the nature of the  
 atoms. The lattice constant is larger for atoms with  
 a larger atomic number and a larger atomic radius.  
 The lattice constant is also a function of the  
 direction in the crystal. The lattice constant is  
 larger in the direction of the chain of atoms than in  
 the perpendicular direction. This is due to the  
 anisotropy of the forces of attraction and repulsion.  
 The lattice constant is also a function of the  
 degree of substitution. The lattice constant is  
 larger for a crystal with a higher degree of  
 substitution than for a crystal with a lower degree  
 of substitution. This is due to the fact that the  
 forces of attraction and repulsion are different for  
 different types of atoms.



15432

CERTIFICATE OF DEATH

15431

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>				c. LENGTH OF STAY IN lb <u>15 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>				d. STREET ADDRESS <u>Route #2, Box 278</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Arthur</u> Last <u>Burcham</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-30-1880</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Levi D. Burcham (D)</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Gentry (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-3662</u>		17. INFORMANT <u>R. Walter Burcham, Conowingo, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral</u> DUE TO <u>Arteriosclerotic C.V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>8 yrs</u> (c)							INTERVAL BETWEEN ONSET AND DEATH <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dementia Hypertrophy Pericarditis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1966</u> to <u>Nov. 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 15</u> 19 <u>67</u> , and that death occurred at <u>2 A.</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>J. Ralph Horky</u>				22b. DATE SIGNED <u>11/15/67</u>		22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky</u>	
22d. ADDRESS <u>Churchville, Maryland</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>18 Nov. 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air, (Harford) Md.</u>	
24. FUNERAL DIRECTOR <u>Louise B. Borge</u> <u>Tarring Funeral Home, Aberdeen, Maryland</u>				25a. REC'D BY REGISTRAR <u>NOV 20 1967</u>			

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15433

## CERTIFICATE OF DEATH

15432

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial</u>		d. STREET ADDRESS <u>977 Chesapeake Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Wm.</u> Last <u>Burns</u>		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/27/1902</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u> Hours <u>12</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Club</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harold Chase, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Charles B. Burns</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Ellen Burns</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Edna E. Burns</u>		Address <u>977 Chesapeake Blvd</u> <u>Harold Chase MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial coronary thrombosis</u> DUE TO (b) <u>ascend (arterio-sclerotic cardiac vac.)</u> DUE TO (c) <u>hypertension</u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>Nov 21</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Nov 21</u> , 19 <u>67</u> , and that death occurred at <u>7:10</u> P.M. from causes on and on the date stated above.			
22a. SIGNATURE <u>Edward J. Simon</u>		22b. DATE SIGNED <u>11/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>		22d. ADDRESS <u>HAURE DE GRACE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/25/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Harold Chase Md.</u>
24. FUNERAL DIRECTOR <u>Frederick R. Harold Chase, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Orlando Judge</u>	

2042

DATE OF BIRTH

88



U.S. GOVERNMENT PRINTING OFFICE  
1964 O - 348-000

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MA</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. LENGTH OF STAY IN 1b <u>D.O.A. - 7:10 P.M.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>128 South Philadelphia Blvd.</u>	
3. NAME OF DECEASED (Type or print) <u>William Edward Calder</u>		4. DATE OF DEATH <u>November 5 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1937</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rubber-Plastic</u>	9. AGE (In years lost birthday) <u>30</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Hartford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William E. Calder</u>		14. MOTHER'S MAIDEN NAME <u>Hazel Wildason</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Oct. 54 - Nov. 62</u>		16. SOCIAL SECURITY NO. <u>213-30-7120</u>	
17. INFORMANT (Mother) <u>838-6376</u> Address <u>Mrs. Hazel W. Wells 1101 Baltimore Pike Bel Air, Maryland 21014</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>7545</u> IMMEDIATE CAUSE (a) <u>Congenital Heart Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald P Palmer M.D.</u>		Address (Street, city, town, or county) <u>Bel Air - MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air Hartford Co., Maryland 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>NOV 8 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

15433

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THE UNIVERSITY OF CHICAGO

1921

THE UNIVERSITY OF CHICAGO

TO THE PRESIDENT OF THE UNIVERSITY OF CHICAGO

FROM THE FACULTY OF THE UNIVERSITY OF CHICAGO

RESOLUTION OF THE FACULTY OF THE UNIVERSITY OF CHICAGO

PASSED AT A MEETING OF THE FACULTY OF THE UNIVERSITY OF CHICAGO

Held at Chicago, Illinois, on the 10th day of May, 1921

That the Faculty of the University of Chicago

do hereby recommend to the Board of Trustees

that the University of Chicago

be authorized to accept the gift of

the sum of \$100,000.00

for the purpose of

the purchase of

the sum of \$100,000.00

for the purpose of

the purchase of

the sum of \$100,000.00

for the purpose of

the purchase of



15435

## CERTIFICATE OF DEATH

15434

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harpe de Grace</u>		c. LENGTH OF STAY in lb <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial</u>		d. STREET ADDRESS <u>Street</u>	
3. NAME OF DECEASED (Type or print) <u>Leo</u> First Middle Last		4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>SEPT. 3, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>76</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>STREET, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jesse Carr</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Cunningham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-12-7499</u>	
17. INFORMANT <u>EMMETT CARR, DARLINGTON, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Coronary Failure</u> DUE TO (b) <u>Chronic Passive Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Arteriosclerosis, extensive</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-11, 1967</u> to <u>11-23, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-23, 1967</u> , and that death occurred at <u>10:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. RALPH HORKY M.D.</u>		22d. ADDRESS <u>CHURCHVILLE, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SOUTHERN</u>	23d. LOCATION (City or Town) (County) (State) <u>DUBLIN, HARFORD, MD.</u>
24. FUNERAL DIRECTOR <u>John H. Harkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>NOV 28 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove orthon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1. Name of the person or organization: *[Faint, illegible text]*  
 2. Address: *[Faint, illegible text]*  
 3. City: *[Faint, illegible text]*  
 4. State: *[Faint, illegible text]*  
 5. Zip: *[Faint, illegible text]*  
 6. Date: *[Faint, illegible text]*  
 7. Signature: *[Faint, illegible text]*  
 8. Title: *[Faint, illegible text]*  
 9. Organization: *[Faint, illegible text]*  
 10. Purpose of the visit: *[Faint, illegible text]*  
 11. Duration of the visit: *[Faint, illegible text]*  
 12. Other information: *[Faint, illegible text]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15436

CERTIFICATE OF DEATH

15435

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>1/12 to 11/29/67</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>Darlington</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>A.</u> Last <u>Chandlee</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01/31/77</u>
9. AGE (In years last birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months <u>90</u> Days <u>29</u> Hours <u>12</u> Min. <u>1</u>	11. IF UNDER 24 HRS. Months <u>90</u> Days <u>29</u> Hours <u>12</u> Min. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lapedum, Md.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm C Knight</u>		14. MOTHER'S MAIDEN NAME <u>Mary Daugherty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-22-1501</u>	
17. INFORMANT <u>Kim Chandler</u>		Address <u>Darlington, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>And a series of small strokes</u> DUE TO (c) <u>over past 2 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> , to <u>Nov 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 27, 1967</u> , and that death occurred at <u>12:21</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips MD</u>		22b. DATE SIGNED <u>12/2/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>Darlington Md 21034</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/2/67</u>		23b. DATE THEREOF <u>12/2/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Darlington</u>		23d. LOCATION (City or Town) (County) (State) <u>Darlington Md</u>	
24. FUNERAL DIRECTOR <u>William S. P. Hancock</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. P. Hancock</u>		25c. REGISTRAR'S SIGNATURE <u>William S. P. Hancock</u>	



15437

CERTIFICATE OF DEATH

15436

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE de GRACE</b>		c. LENGTH OF STAY IN 1b <b>22 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD Memorial Hospital</b>		e. STREET ADDRESS <b>322 So. Union Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Patrick Cunningham</b>		4. DATE OF DEATH <b>Nov. 12 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/1927</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Gov.</b>		11. BIRTHPLACE (County & State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>George C. Cunningham</b>		14. MOTHER'S MAIDEN NAME <b>Madeline Stitely</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>3223 Union Ave</b>	
17. INFORMANT <b>Ylanda M. Cunningham</b>		18. CAUSE OF DEATH (Enter only one cause per line to (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of the coronary artery</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <b>Nov. 12 1967</b> , and that death occurred at <b>150 M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>11/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Angel Hill</b>	23d. LOCATION (City or Town) (County) (State) <b>Harford County, Md.</b>
24. FUNERAL DIRECTOR <b>Pennington Co., Harford County, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

12418

STATE OF TEXAS

12418

*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*

NOT A VALID DOCUMENT

TO AGENT OF INSURANCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			c. LENGTH OF STAY in ib <b>9 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>325 Choice Street</b>					d. STREET ADDRESS <b>325 Choice Street</b>				
3. NAME OF DECEASED (Type or print) <b>Raymond Stuart DeVane</b>					4. DATE OF DEATH <b>November 12, 1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 14, 1876</b>		9. AGE (In years lost birthday) yrs. <b>91</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Sampson Co., N.C.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>William T. DeVane</b>					14. MOTHER'S MAIDEN NAME <b>Elizabeth Newkirk</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>239-10-4240</b>		17. INFORMANT <b>Daughter 838-5415</b> <b>Mrs. Elizabeth Wilkinson</b> <b>325 Choice St. Bel Air, Md. 21014</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 ACUTE CARDIO-RESP. FAILURE</b> DUE TO (b) <b>PULMONARY EDEMA</b> DUE TO (c) <b>ADVANCED CARDIO-VASC. SCLEROSIS</b>								INTERVAL BETWEEN ONSET AND DEATH <b>1 HR</b> <b>2 HRS</b> <b>6 MONTHS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>—</b> a.m. <b>—</b> p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>12 Nov</b> , 1967, that (I) (we) last saw the deceased alive on <b>12 Nov</b> , 1967, and that death occurred at <b>6:45 A</b> M, from causes and on the date stated above.									
22a. SIGNATURE <b>H. Proctor Sidwell M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 12, 1967</b>			
22c. PHYSICIAN'S NAME (Type) <b>H. Proctor Sidwell, M.D.</b>				22d. ADDRESS <b>401 Franklin St., Bel Air, Md. 21014</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 14, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LaFayette Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Fayetteville, Cumberland, N.C.</b>			
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>				W. Broadway & Williams <b>Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

Joseph William Foster



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UNITED STATES OF AMERICA

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Vol 11

9 years

Vol 11

325 Choice Street

325 Choice Street

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November

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Vol 11

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325 Choice Street  
Vol 11, N.C.

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Vol 11

Vol 11

PULMONARY EDENIA

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Vol 11

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X

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CERTIFICATE OF DEATH

15439

15438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>17 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>112 S. Reed St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAROLD</u> <u>Kenneth</u> <u>Ditzenberger</u>		4. DATE OF DEATH Month Day Year <u>November 6</u> <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 5, 1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Standard Lab. Tech.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electronics-Chemical</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LEBANON, INDIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>OTTO S. Ditzenberger</u>		14. MOTHER'S MAIDEN NAME <u>VESTA MAY MORRIS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>314-12-4970</u>	
17. INFORMANT (Name) <u>Mrs. CAROLINE B. DITZENBERGER</u>		Address <u>112 S. REED ST. BEL AIR, MD. 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446x</u> <u>Uremia and irreversible renal</u> DUE TO <u>damage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gouty nephritis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>poss. 2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Renal Hypertension + Cardiac Decompensation</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-21</u> , 19 <u>67</u> , to <u>11-6</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11-6</u> , 19 <u>67</u> , and that death occurred at <u>10:25</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>11/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Haure de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Bel Air Harford Co. Maryland</u>	
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>	
ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
15440															
15439															
1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fawn Grove (rural)</b> c. LENGTH OF STAY IN 1b <b>1 month</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Onion Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jarrettsville</b> d. STREET ADDRESS <b>Salem Church Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>William Martin Emrick</b>						4. DATE OF DEATH <b>November 15, 1967</b>									
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1878</b>		9. AGE (In years last birthday) <b>89 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. farming</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Jarrettsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Jacob Emrick</b>						14. MOTHER'S MAIDEN NAME <b>Mary Bahr</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>						16. SOCIAL SECURITY NO. <b>217-46-0034</b>						17. INFORMANT <b>Mrs. Mary C. Onion</b> Address <b>RD # 1 Fawn Grove, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, myocardial failure</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Diabetes mellitus, chr. prostatic</b> DUE TO (c) <b>Obstruction and old age.</b>												17321		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Tractor accident -3 months previous.</b>												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 8, 1967</b> to <b>Nov. 16, 1967</b> that (I) (we) last saw the deceased alive on <b>Nov. 16, 1967</b> and that death occurred at <b>5:30 P.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Norman H. Gemmill</b> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <b>11/16/67</b>									
22c. PHYSICIAN'S NAME (Type) <b>Norman H. Gemmill, M.D.</b>						22b. DATE SIGNED 22d. ADDRESS <b>Stewartstown, Pa. 17363</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>11/18/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fawn Grove Methodist</b>		23d. LOCATION (City, town or county) (State) <b>Fawn Grove, Pa.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kurtz</b> ADDRESS <b>Jarrettsville, Md.</b>						25a. REC'D BY REGISTRAR <b>NOV 17 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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LETTER OF 10-10-57

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## CERTIFICATE OF DEATH

15440

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland...</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Citizens Nursing Home</b>		d. STREET ADDRESS <b>Route #3, Box 285</b>	
3. NAME OF DECEASED (Type or print) First <b>GLADYS</b> Middle <b>S.</b> Last <b>FLESHMAN</b>		4. DATE OF DEATH <b>November 30, 1967</b> Month <b>November</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>x</b> <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1900</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George L. Rand</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-28-3904</b>	
17. INFORMANT <b>Raymond E. Wright, Woodhaven, N.Y. 11421</b>		18. ADDRESS <b>8046 90th Road</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>Diabetes Mellitus ; Arteriosclerotic Heart Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-22-</b> , 19 <b>56</b> , to <b>11-30-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11-30-</b> , 19 <b>67</b> , and that death occurred at <b>4:00 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Peter P. Rodman</b>		22b. DATE SIGNED <b>12-1-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Peter P. Rodman, M.D.</b>		22d. ADDRESS <b>8 Law Street, Aberdeen, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>4 Dec. 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spesutia Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Perryman, (Harford) Maryland</b>
24. FUNERAL DIRECTOR <b>Tarring Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DEC 4 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. REGISTRAR'S NAME <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15442

## CERTIFICATE OF DEATH

15441

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>305 Wakefield Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Eloise</u> Middle <u>Naomi</u> Last <u>Gibbs</u>		4. DATE OF DEATH Month <u>November</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 15, 1909</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>East Springfield, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOVELL D. HAMMOND</u>		14. MOTHER'S MAIDEN NAME <u>CLARA L. STEARNS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>292-07-1264</u>	
17. INFORMANT (Husband) <u>838-7158</u> <u>Mr. Almon V. Gibbs</u>		Address <u>305 Wakefield Drive</u> <u>Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO (b) <u>Anteroseptal myocardial infarction</u> DUE TO (c) <u>A.S. C.V.D.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus - 7 years</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>11/21</u> , 19 <u>67</u> , to <u>11/23</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>11/22</u> , 19 <u>67</u> , and that death occurred at <u>12 A.</u> M., from causes and on the date stated above.	
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>11/23/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LA CARPE Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>LA CARPE, OTTAWA Co. Ohio</u>
24. FUNERAL DIRECTOR <u>JOSEPH WILLIAM FOSTER</u> <u>W. Broadway &amp; Williams St</u> <u>Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18 & 20a-20f  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12-6-67 mt

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15442

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>2.44</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>RD 2, Box 114</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CARVILLE CARRILLET TAYLOR GILBERT</b> Middle Lost		4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 11, 1882</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MARTIN LEE GILBERT</b>		14. MOTHER'S MAIDEN NAME <b>LUCY VIRGINIA HUGHES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-26-6334</b>	
17. INFORMANT <b>Mr. AMOS H. HARLAN, Havre de Grace, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8164</b> IMMEDIATE CAUSE (a) <b>Laceration of Aorta</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver went around curve, kept in wrong lane &amp; hit another car head-on.</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:45</b> hour o.m. <b>11-17</b> 19 <b>67</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Street</b>		20f. (City or town) (County) (State) <b>Aberdeen Harford Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Werner U. Spitz</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>Nov. 20, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WESLEYAN CHAPEL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>HARFORD Co. MD</b>	
24. FUNERAL DIRECTOR <b>R. Madison Mitchell, HAVRE DE GRACE, MD.</b>		25a. REC'D BY REGISTRAR <b>NOV 21 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

92022

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

MEMORANDUM

TO : DIRECTOR

FROM : SAC, NEW YORK

SUBJECT :

RE : [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible signature]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

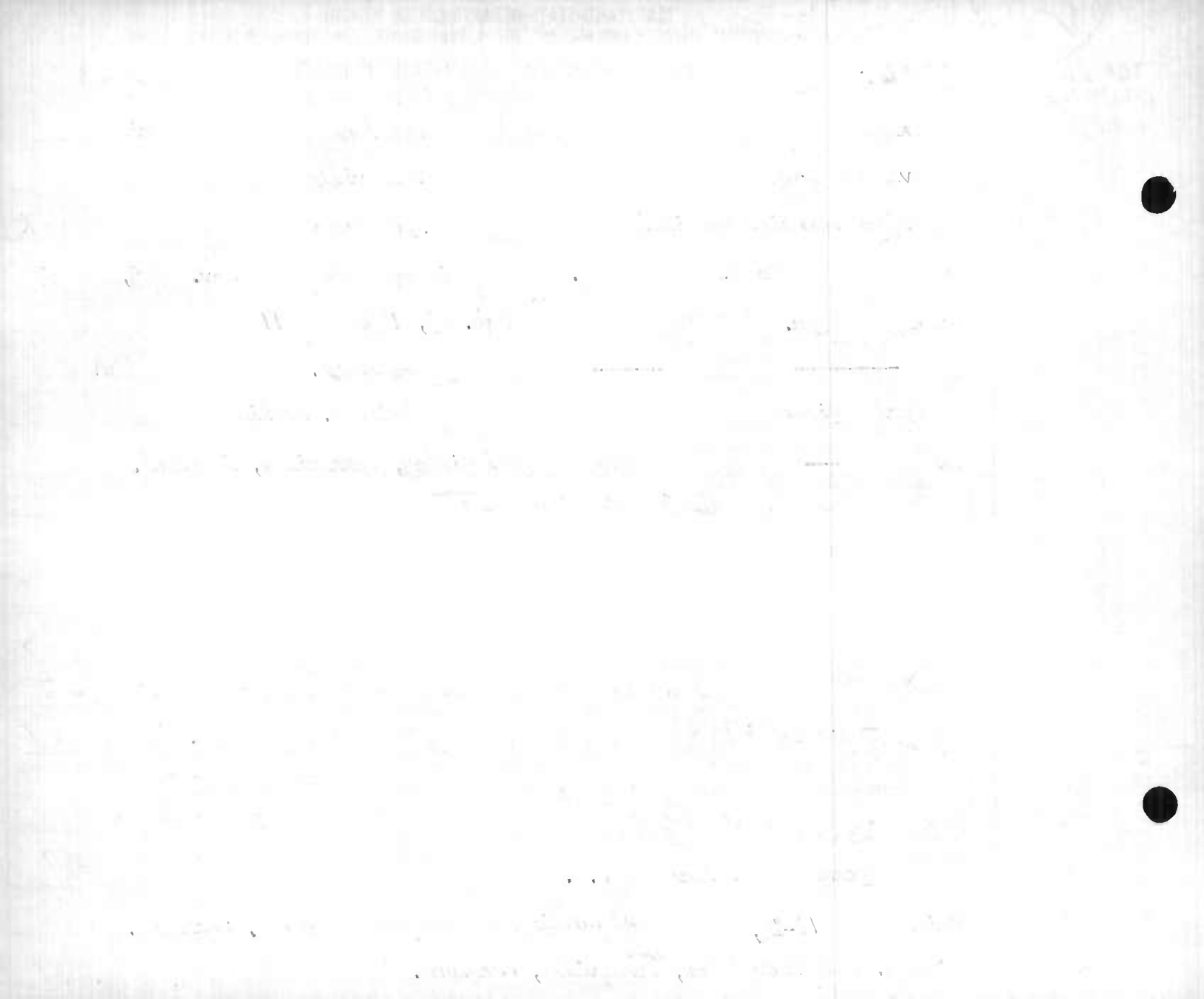
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harpford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Elm Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Roger</u> Middle <u>J.</u> Last <u>Gilley</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>-----</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	9. AGE (In years lost birthday) yrs. <u>11</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Earl Gilley</u>		14. MOTHER'S MAIDEN NAME <u>Betty H. Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Earl Gilley, Perryville, Maryland.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GS Chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Brother's cleaning Gun + it went off</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>8 P.M.</u> <u>11-25-67</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Perryville Cecil Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P. Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald Palmer M.D.</u>		22. DATE SIGNED <u>11-26-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-28-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Colona, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Lee H. Patterson &amp; Son, Perryville, Maryland.</u>		25. REC'D BY REGISTRAR <u>NOV 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



CERTIFICATE OF DEATH

15445

15444

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>3 1/2 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS <u>215 Fulford Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home - Harford Co</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jessie</u> Middle <u>MONROE</u> Last <u>Grove</u>		4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>♀</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10-4-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Monroe</u>		14. MOTHER'S MAIDEN NAME <u>Mercy Norris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-44-6180</u>	
17. INFORMANT <u>Self</u>		Address <u>Harry St.A. O'Neill</u> <u>1 wall street</u> <u>Bel Air, Md. 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCVD</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Osteoarthritis - Osteoporosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/28</u> , 19 <u>67</u> , to <u>11/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>67</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Gyolcsai MD</u>		22b. DATE SIGNED <u>11/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. GRIGOLEIT</u>		22d. ADDRESS <u>HARVEY De Grace</u> <u>MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 28, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Harford Co., Md. 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>	
ADDRESS <u>W. Broadway &amp; Williams St.</u> <u>Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

15445

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>	
c. LENGTH OF STAY IN 1b <u>2 days</u>		d. STREET ADDRESS <u>Concord Cove Apts.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Douglas Alton</u> First Middle Last <u>HALL</u>		4. DATE OF DEATH <u>November 17</u> 19 <u>67</u> Month Day Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15 1967</u>
9. AGE (In years lost birthday) yrs. <u>2</u>		10. IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mr</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mr</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Douglas Hall</u>		14. MOTHER'S MAIDEN NAME <u>Ann Paige Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>none</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO (b) <u>1 day</u> DUE TO (c) <u>1 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> , 19 <u>67</u> , to <u>Nov 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 17</u> 19 <u>67</u> , and that death occurred at <u>4:20</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yun</u>		22b. DATE SIGNED <u>11/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YUN</u>		22d. ADDRESS <u>HAURE DE GRACE MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Kuthuran</u>	23d. LOCATION (City or Town) (County) (State) <u>Chesapeake, MD</u>
24. FUNERAL DIRECTOR <u>Funeral Home, Harford, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 22 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

15447

15446

1. PLACE OF DEATH a. COUNTY <u>Hartford.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford-de-Grace</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>206 Duryea Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Leonard</u> Last <u>Huebscher</u>		4. DATE OF DEATH Month <u>11</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/1902</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Charles L. Huebscher Sr.</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Omerick</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>	
16. SOCIAL SECURITY NO. <u>705-03-5344</u>		17. INFORMANT <u>Alma P. Huebscher, 206 Duryea Dr. Joppa, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Extensive posterolateral myocardial infarction</u> DUE TO (c) <u>Posterior Coronary thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>1 day</u> <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 18, 1967</u> to <u>11/18, 1967</u> , that (I) (we) lost the deceased alive on <u>11/18, 1967</u> , and that death occurred at <u>9:45 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>11/18/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Hartford-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/22/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethlehem Stiltz Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Glen Rock R.D. 3, Pa.</u>
24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



15448

## CERTIFICATE OF DEATH

15447

1. PLACE OF DEATH o. COUNTY <u>Harford</u> <u>Havre De Grace</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN lb <u>15 days</u>		<u>Havre De Grace</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>Route 1, Fox Road Box 269</u>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Jensen</u> Last <u>Nov.</u>		4. DATE OF DEATH Month <u>18</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-10</u>
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>18</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day/Mon - Hoof</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>Denmark</u>	
13. FATHER'S NAME <u>Anders Larson</u>		14. MOTHER'S MAIDEN NAME <u>Anna Maria Van Coesteren</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-40-8106</u>	
17. INFORMANT <u>Elmer J. Miller</u>		Address <u>Fox Road Harford Co Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621</u> <u>Asphyxia</u> DUE TO (b) <u>Bronchogenic Carcinoma</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>67</u> , to <u>11-18</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>11-16</u> 19 <u>67</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Anders Hink</u>		22b. DATE SIGNED <u>11-20-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/21/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Havre de Grace Md</u>	
24. FUNERAL DIRECTOR <u>Conroy &amp; Son</u>		ADDRESS <u>Havre de Grace Md</u>	
25a. REC'D BY REGISTRAR DATE <u>NOV 22 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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2023

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15449

15448

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>30-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home Market St.</u>		d. STREET ADDRESS <u>1437 Stonewood Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>A.</u> Last <u>Leimkuhler</u>		4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years less birthday) <u>81</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene E. Peake</u>		14. MOTHER'S MAIDEN NAME <u>? Sword</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Eugene Leimkuhler</u>		Address <u>7 Sherwood Rd. Annapolis</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5192 Congestive Heart Failure</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u>Pleural effusion - etiology undetermined</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u> <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles J. Foley Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Charles J. Foley Jr.</u>		22d. ADDRESS <u>Havre de Grace, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/13/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>John A. Moran Inc.</u>		25a. REC'D BY REGISTRAR <u>3000 E. Baltimore Street</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 14 1967</u>	

Name of Deceased		Date of Death	
Age		Sex	
Place of Birth		Cause of Death	
Occupation		Manner of Death	
Residence		Burial Place	
Signature of Physician		Signature of Registrar	
Signature of Witness		Signature of Coroner	
Signature of Undertaker		Signature of Funeral Home	
Signature of Minister		Signature of Cemetery	
Signature of Family		Signature of Friends	
Signature of Neighbors		Signature of Community	
Signature of Church		Signature of Society	
Signature of School		Signature of Government	
Signature of State		Signature of Nation	
Signature of World		Signature of Universe	
Signature of God		Signature of Heaven	
Signature of Hell		Signature of Earth	
Signature of Air		Signature of Fire	
Signature of Water		Signature of Earth	
Signature of Sky		Signature of Sea	
Signature of Land		Signature of Mountains	
Signature of Rivers		Signature of Lakes	
Signature of Forests		Signature of Fields	
Signature of Towns		Signature of Cities	
Signature of Countries		Signature of Continents	
Signature of Oceans		Signature of Planets	
Signature of Stars		Signature of Galaxies	
Signature of Universe		Signature of God	

## CERTIFICATE OF DEATH

15449

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN lb <u>1 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>RD 2 Box 162</u>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First Middle Last <u>Lewis</u>		4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 15, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>218-28-2135</u>	
17. INFORMANT <u>RUTH C. LEWIS, DARLINGTON, MD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY INSUFFICIENCY - acute</u> DUE TO (b) <u>ADAMS STOKES Syndrome</u> DUE TO (c) <u>CORONARY ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>14 hr</u> <u>54 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 6</u> , 19 <u>60</u> , to <u>Nov 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov 20</u> , 19 <u>67</u> , and that death occurred at <u>9 P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips</u>		22b. DATE SIGNED <u>11/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>DARLINGTON MD</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Nov. 24, 1965</u>	23c. NAME OF CEMETERY OR CREMATORY <u>DARLINGTON</u>	23d. LOCATION (City or Town) (County) (State) <u>DARLINGTON, MD.</u>
24. FUNERAL DIRECTOR <u>John A. Ashkins, DELTA, PA.</u>		25a. REC'D BY REGISTRAR <u>NOV 27 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Richard J. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

23812

BOARD OF DIRECTORS

UNITED STATES OF AMERICA  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15451 Item #2d Film #G395 12/1/67 ph

## CERTIFICATE OF DEATH

15450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase</u> c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harold Chase Md. 12.1</u> d. STREET ADDRESS <u>511 Green St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna Virginia Martin</u> First Middle Last 4. DATE OF DEATH <u>11/25/67</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/22/1869</u> 9. AGE (In years last birthday) <u>98</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harold Chase</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>J. Patrick Martin</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Burkett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Dr. John H. Byers</u> Address <u>Harold Chase Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> <u>4221</u> DUE TO (b) <u>A.S.C.U.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Blood dyscrasia &amp; thrombocytopenia etiology?</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 11</u> , 19 <u>64</u> , to <u>Nov. 28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/25</u> , 19 <u>67</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loom</u> M.D.		22b. DATE SIGNED <u>11/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loom, M.D.</u>		22d. ADDRESS <u>Harold Chase, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>—</u>		23b. DATE THEREOF <u>11/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Francis</u>		23d. LOCATION (City or Town) (County) (State) <u>Abingdon Md.</u>	
24. FUNERAL DIRECTOR <u>Livingston R. Harold Chase Md</u> ADDRESS		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 28 1967</u>			



10

15452

## CERTIFICATE OF DEATH

15451

1. PLACE OF DEATH a. COUNTY <b>Harford</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b> c. LENGTH OF STAY IN lb <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b> d. STREET ADDRESS <b>R.D. 1, Box 389</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b> First <b>FREDDIE</b> Middle <b>McCOMMONS</b> Last		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1870</b> 9. AGE (In years lost birthday) yrs. <b>97</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Harford County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James McCommons</b>		14. MOTHER'S MAIDEN NAME <b>Martha Bunce</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-2809</b>	
17. INFORMANT <b>Mrs. Mary Siebert, Rd.1, Aberdeen, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>177X</b> IMMEDIATE CAUSE (a) <b>generalized carcinoma</b> DUE TO (b) <b>carcinoma of prostate</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>~ 5 1/2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>congestive heart failure</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 9</b> , 19 <b>67</b> , to <b>Nov. 19</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 19</b> , 19 <b>67</b> , and that death occurred at <b>6:15 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>B. J. Plunkett, Jr.</b>		22b. DATE SIGNED <b>11-20-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>B. J. Plunkett, Jr. M.D.</b>		22d. ADDRESS <b>617 W. Bal Air, Ave. Aberdeen, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>22 Nov. 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Rack Run Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Havre de Grace (Harford) Md.</b>
24. FUNERAL DIRECTOR <b>Webster Macomber Sr.</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 24 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10. *Staphylinus*

CERTIFICATE OF DEATH

15453

15452

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN lb <u>9 hrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville</u>		d. STREET ADDRESS <u>Rt #1. Box 83a</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nelson Augustus McVey</u>		4. DATE OF DEATH <u>11 16 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 21, 1877</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H McVey</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Bailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-54-8313</u>	
17. INFORMANT <u>Mrs. Robert Payne</u>		Address <u>Churchville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Cardiac Failure</u> DUE TO (c) <u>Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Fracture Left Hip</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-16, 1967</u> to <u>11-16, 1967</u> that (I) (we) last saw the deceased alive on <u>11-16, 1967</u> , and that death occurred at <u>9:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Leyte-Vidal</u>		22b. DATE SIGNED <u>17 Nov. 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Sanlago Leyte-Vidal, M.D.</u>		22d. ADDRESS <u>Aberdeen, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-19-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Aberdeen, Maryland</u>	
24. FUNERAL DIRECTOR <u>John S. Tarring</u>		25a. REC'D BY REGISTRAR <u>NOV 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15454

15453

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>11 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>620 S. MAIN Street</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK Elwood Monks</u>		4. DATE OF DEATH <u>November 28 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 14, 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Driver - Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bus Transportation</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hartford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Archer Monks</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Phelps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WW #1</u>		16. SOCIAL SECURITY NO. <u>215-01-3990</u>	
17. INFORMANT (with) <u>838-3355</u> Address <u>620 South Main Street</u>		18. <u>Mrs. Laura A. Monks</u> <u>Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Bladder obstruction</u> DUE TO (c) <u>Metastatic Ca of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>20 days</u> <u>5 months</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11-18, 1967</u> to <u>11-28, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-28, 1967</u> , and that death occurred at <u>6 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A.W. Grigoleit MD</u>		22b. DATE SIGNED <u>11/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. GRIGOLEIT</u>		22d. ADDRESS <u>HAVRE de GRACE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Dec 1, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	23d. LOCATION (City or Town) (County) (State) <u>Bel Air, Hartford Co., Md. 21014</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>DEC 4 1967</u>	
25b. REGISTRAR'S SIGNATURE			



3458

TESTIMONY OF DEATH

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## CERTIFICATE OF DEATH

15455

15454

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oden 10 n.</u>	
c. LENGTH OF STAY IN 1b <u>8 days</u>		d. STREET ADDRESS <u>P.O. Box 134</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert F. Moore</u>		4. DATE OF DEATH <u>11-5-67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 1, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEELWORKER (RET)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VAN HOE, N. CAR</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>213-09-1817</u>	
17. INFORMANT <u>Robert Anthony Moore</u>		Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive and arteriosclerotic</u> DUE TO (c) <u>Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Terminal Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 20, 1967</u> to <u>Nov 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 5, 1967</u> , and that death occurred at <u>4:45 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward C. Loo, M.D.</u>		22b. DATE SIGNED <u>11/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Harre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>NOV 9, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>TROUTMAN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>STATESVILLE N. CAR.</u>
24. FUNERAL DIRECTOR <u>Harre de Grace</u>		25a. REC'D BY REGISTRAR <u>NOV 15 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

1914

STATE OF NEW YORK

25

No.	Name of Plant	Locality	Collector	Date	Height	Fls.	Fruit	Remarks
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RECEIVED  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.  
JUN 10 1914

CERTIFICATE OF DEATH

15456

15455

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL TOPPA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL TOPPA</b> <b>121</b>	
c. LENGTH OF STAY IN 1b <b>8 YRS.</b>		d. STREET ADDRESS <b>1003 PULASKI HIGHWAY</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1003 PULASKI HIGHWAY</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>SIMON</b> First Middle Last <b>MOTOWYLAK</b>		4. DATE OF DEATH Month <b>11</b> Day <b>24</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-86</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET U.S. GOVT</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>HARBOR</b>		11. BIRTHPLACE (County & State, or foreign country) <b>AUSTRIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>PETE MOTOWYLAK</b>	
14. MOTHER'S MAIDEN NAME <b>ANNA CHACHLA</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>111-01-3210</b>		17. INFORMANT Address <b>JULIA FROMLING TOPPA, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>4341</b> DUE TO (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Congestive Heart Failure</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> , to <b>19</b> , that (I) (we) lost saw the deceased alive on <b>11/27/67</b> , and that death occurred at <b>11/27/67</b> M, from causes on and on the date stated above.			
22a. SIGNATURE <b>LOUIS KAHN</b>		22b. DATE SIGNED <b>11/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS KAHN</b>		22d. ADDRESS <b>EDGEWOOD, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-27-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. ROSE OF LIMA</b>	23d. LOCATION (City or Town) (County) (State) <b>CHESAPEAKE CITY MD</b>
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>		25a. REC'D BY REGISTRAR <b>FLATON, MD</b>	
25b. REGISTRAR'S SIGNATURE <b>Johnas Judge</b>		DATE <b>DEC 5 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

12422

12422

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15457

15456

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill (Rural)</u>		c. LENGTH OF STAY IN lb <u>Forest Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hess Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alexandras Orantass</u> First Middle (Orantass) Last		4. DATE OF DEATH <u>November, 27</u> 19 <u>67</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21, 1912</u>
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JONAS ORANTAS</u>		14. MOTHER'S MAIDEN NAME <u>ONA Griedrius</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-30-5784</u>	
17. INFORMANT (with) <u>838-5110</u> Address <u>Mrs. Veronika V. Orantass Forest Hill Md. 21054</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bo/Air, Md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>11-27-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BEL Air Memorial Gardens</u>
23d. LOCATION (City or Town) (County) (State) <u>BEL Air, Hartford Co, Maryland 21014</u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St. BEL Air, Maryland 21014</u>		25. REC'D BY REGISTRAR <u>NOV 29 1967</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1952

U.S. DEPARTMENT OF AGRICULTURE

1952

Report of the  
Secretary of Agriculture  
to the President  
of the United States  
on the  
State of the  
Agriculture  
of the United States  
in 1951

Report of the  
Secretary of Agriculture  
to the President  
of the United States  
on the  
State of the  
Agriculture  
of the United States  
in 1951

Report of the  
Secretary of Agriculture  
to the President  
of the United States  
on the  
State of the  
Agriculture  
of the United States  
in 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MARYLAND STATE DEPARTMENT OF HEALTH

15458

CERTIFICATE OF DEATH

15457

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Churchville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RD# 1, Box 427</b>			d. STREET ADDRESS <b>RD #1, Box 427</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>ADAIR</b> Last <b>PAGE</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>8th</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9th 1883</b>		9. AGE (In years last birthday) yrs. <b>84</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Anderson</b>			14. MOTHER'S MAIDEN NAME <b>Mary Adair M. Kee</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-38-2417</b>		17. INFORMANT <b>Lee V. Page, 704 Old Joppa Rd. Joppa, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221 Congestive Heart Failure</b> DUE TO (b) <b>Advanced Arteriosclerotic CV Disease</b> DUE TO (c) <b>5 1/2 yrs</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>March 1962</b> , to <b>Nov 7, 1967</b> , that (I) (we) lost saw the deceased alive on <b>Nov 7, 1967</b> , and that death occurred at <b>6:00 AM</b> , from causes and on the date stated above.					
22a. SIGNATURE <b>J. Ralph Horky</b>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <b>J. Ralph Horky, MD.</b>			22d. ADDRESS <b>Churchville, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/10/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Churchville Presbyterian</b>	23d. LOCATION (City or Town) (County) (State) <b>Churchville, Harford, Md.</b>		
24. FUNERAL DIRECTOR <b>Tarring Funeral Home</b> <b>Aberdeen, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>NOV 13 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	

1955

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May 1955

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May 1955

May 1955

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15459

CERTIFICATE OF DEATH

15458

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cardiff</b>		c. LENGTH OF STAY IN 1b <b>78 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cardiff</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Main Street</b>		d. STREET ADDRESS <b>Main Street</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Parry</b> Last <b>Parry</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1889</b>
9. AGE (In years last birthday) <b>78 yrs.</b>		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Cardiff, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas Parry</b>	
14. MOTHER'S MAIDEN NAME <b>Carrie Stull</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Carrie Bryson, Cardiff, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO <b>Arteriosclerotic C-V Disease</b> (c) <b>Arteriosclerotic C-V Disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>11/10/67</b> , 19 <b>67</b> , to <b>11/11/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/10/67</b> 19 <b>67</b> , and that death occurred at <b>4 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Josiah A. Hunt</b>		22b. DATE SIGNED <b>Nov. 13, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Josiah A. Hunt M.D.</b>		22d. ADDRESS <b>Delta, Pa.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/14/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Slate Ridge Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Delta, York Co., Pa.</b>
24. FUNERAL DIRECTOR <b>John H. Harkins</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Continuing to  
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10/10/07

10/10/07

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10/10/07

FOR STATE  
HEALTH DEPT.

15460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15459

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>	
c. LENGTH OF STAY IN 1b <b>1 1/2 years</b>		d. STREET ADDRESS <b>602 South Shamrock</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Main Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Otto</b> Middle <b>Elmer</b> Last <b>Peterson</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1884</b> <b>June 20, 1885</b> <b>82</b> yrs.
9. AGE (In years lost birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>23</b> Days <b>8</b> Hours <b>3</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>New Winsor, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew John Peterson</b>		14. MOTHER'S MAIDEN NAME <b>Emma C. Peterson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>503-12-7114-A</b>	
17. INFORMANT <b>(Son) 838-4408</b>		18. ADDRESS <b>602 S. Shamrock Bel Air, Md. 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO <b>ASCVD</b> (b) <b>(long standing)</b> DUE TO <b>(long standing)</b> (c) <b>(long standing)</b>			INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ASCVD Long Standing</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip W. Heuman</b> M.D.		22. DATE SIGNED <b>Nov. 13, 1967</b>	
EXAMINER'S NAME (Type) <b>Philip W. Heuman, M.D. 307 Hickory Ave, Bel Air, Md. 21014</b>		23. LOCATION (City or Town) (County) (State) <b>Denver, Colorado</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 17, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairmont Cemetery</b>	
24. FUNERAL DIRECTOR <b>W. Broadway &amp; Williams</b> <b>Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>NOV 16 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

Joseph William Foster

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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Correspondence: *Journal of Interpersonal Violence* 26(10), 2011, pp. 2491-2504. © 2011 Sage Publications. 10.1177/0886260511417101

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## CERTIFICATE OF DEATH

15460

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>8 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Citizens Nursing Home</b>		d. STREET ADDRESS <b>821 Baltimore Pike</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Edith</b> Last <b>Pue</b>		4. DATE OF DEATH Month <b>11</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 17, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	9. AGE (In years lost birthday) <b>75 yrs.</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Franklin Welch</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Wayson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-01-1262</b>	
17. INFORMANT (Nephew) 1-25-M4-4280 Address <b>Mr. Norman S. Lightcap 10 East Golf Club Lane Pott, Pennsylvania 19301</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis, left</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic C.V. Disease</b> DUE TO (c) <b>6 yrs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 wks.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 16, 1967</b> , to <b>Nov 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov 23, 1967</b> , and that death occurred at <b>11 A. M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>J. Ralph E. Horky, M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>11/23/67</b>
22c. PHYSICIAN'S NAME (Type) <b>J. Ralph E. Horky, M.D.</b>		22d. ADDRESS <b>Churchville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>November 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Memorial Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Bel Air Harford Co. Maryland 21014</b>
24. FUNERAL DIRECTOR <b>Joseph William Foster</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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THE UNIVERSITY OF CHICAGO  
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FOR STATE HEALTH DEPT. 1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15462

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15461

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DoA Hartford Memorial Hospital</u>			d. STREET ADDRESS <u>Koppeler Trailer Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>April L Richmond</u>			4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30 1965</u>		9. AGE (In years last birthday) yrs. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Daniel Arden Richmond</u>			14. MOTHER'S MAIDEN NAME <u>Joyce Ann Hardiman</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>James Hardiman</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>9160</u> IMMEDIATE CAUSE (a) <u>Third Degree Burns Body</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in Trailer Fire</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>11-8</u> <u>1967</u> p.m.		20d. INJURY OCCURRED <u>2</u> While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Trailer</u>	
		20f. (City or town) (County) (State) <u>Rising Sun Cecil Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald E Palmer</u> M.D.		22. DATE SIGNED <u>11-8-67</u>			
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov 11 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem</u>	
24. FUNERAL DIRECTOR <u>W. H. Mullen</u>		ADDRESS <u>W. H. Mullen, W. Rising Sun Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 13 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH REPORT

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15463

15462

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Azusa de Grace D.O.H.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DGA Hartford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daniel A Richmond Jr</u>		4. DATE OF DEATH <u>November 8 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1966</u>
9. AGE (In years last birthday) yrs. <u>1</u>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Daniel Arden Richmond</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Ann Hardiman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>James Hardiman</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third Degree Burns Body</u> DUE TO (b) <u>9160</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>9160</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Burned in Trailer-Fire</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>11-8-67</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rising Sun Cecil Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>David C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bo/Ai</u>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-8-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>Colord Cecil Md</u>	
24. FUNERAL DIRECTOR <u>W E Mc Mullen</u>		ADDRESS <u>Rising Sun, Md</u>	
25a. REC'D BY REGISTRAR <u>NOV 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15464

15463

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ABERDEEN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>HARFORD MEMORIAL HOSP.</b>		d. STREET ADDRESS <b>427 BALTIMORE STREET</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>STERLING DUMAP SHEPPARD</b>		4. DATE OF DEATH Month Day Year <b>NOV 11 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 11, 1942</b>
9. AGE (In years last birthday) <b>25</b> yrs.		10. AGE (In years last birthday) <b>5</b> yrs.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Peter Jojner</b>		14. MOTHER'S MAIDEN NAME <b>Genevieve Sheppard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>VI/1961 to 1/1964</b>		16. SOCIAL SECURITY NO. <b>212-40-7472</b>	
17. INFORMANT <b>Mrs. Sandra Sheppard - Aberdeen, Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MULTIPLE HEAD INJURIES, BROKEN NECK</b> DUE TO (b) <b>AUTO ACCIDENT</b> DUE TO (c) <b>INSTANT</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>NONE</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>LOST CONTROL OF AUTO - RAN INTO PILE OF ROCKS</b>	
20c. TIME OF INJURY Month. Day. Year Hour a. m. <b>4:55 PM NOV 11 1967</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STREET</b>		20f. (City or town) (County) (State) <b>HAVRE DE GRACE, HARFORD, MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Philip W. Heuman</b>		DATE SIGNED <b>NOV 11, 1967</b>	
EXAMINER'S NAME (Type) <b>PHILIP W. HEUMAN, MD</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 16, 1967</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Harford Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elmer E. Bullock</b>		24a. REC'D BY REGISTRAR <b>NOV 20 1967</b>	
ADDRESS <b>Havre de Grace, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

MEDICAL CERTIFICATION



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15465

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15464

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen- Rural</b>		c. LENGTH OF STAY IN lb <b>25 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>none</b>		d. STREET ADDRESS <b>Box 82A, R.D. #3</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>WALTER</b> Last <b>SIEWIERSKI</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>4</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 27, 1892</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner-Opr., Service Sta.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Balto Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Siewierski</b>		14. MOTHER'S MAIDEN NAME <b>Anna Ziegalski</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-14-5024A</b>	
17. INFORMANT <b>Mrs. Madeline Francis, Montreal Drive, R.D. #1</b>		Address <b>Aberdeen, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1</b> , 19 <b>67</b> , to <b>Nov. 4</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Nov. 3</b> , 19 <b>67</b> , and that death occurred at <b>8 A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Gerald C. Palmer</b>		22b. DATE SIGNED <b>11-6-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerald C. Palmer</b>		22d. ADDRESS <b>Bel Air, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 7, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore Md</b>
24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son, Abingdon, Md.</b>		25a. REC'D BY REGISTRAR <b>Nov 7 1967</b> DATE	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# CONTINUATION OF REPORT

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15466

## CERTIFICATE OF DEATH

15465

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN tb <u>25 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u> <u>121</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>257 Lewis Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lillie</u> Middle <u>P.</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>November</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>81</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Welford, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Cesar Hunter</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-07-4254</u>	
17. INFORMANT <u>Mrs. Elijah Smith, Havre de Grace, Md.</u>		Address <u>257 Lewis St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular thrombosis</u> DUE TO (b) <u>Hypertensive vasc. disease.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>25 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 4</u> , 1967, to <u>Nov 27</u> , 1967, that (I) (we) last saw the deceased alive on <u>Nov 27</u> , 1967, and that death occurred at <u>2:30</u> AM, from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>L.I. Mezei M.D.</u>		22d. ADDRESS <u>601 S. Union Ave., Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-2-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, Havre de Grace, Md.</u>
24. FUNERAL DIRECTOR <u>Otelia J. Bullock, Havre de Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 5 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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15467

## CERTIFICATE OF DEATH

15466

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>09-18- to 11/15/67</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Citizens Nursing Home</b>				d. STREET ADDRESS <b>202 Sunnyside Dr.</b>	
3. NAME OF DECEASED (Type or print) <b>MAE ELIZA STINE</b>		4. DATE OF DEATH <b>Nov. 15 1967</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-5-85</b>		9. AGE (In years lost birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Bradshaw, Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Akers (D)</b>	
14. MOTHER'S MAIDEN NAME <b>Alice Cullum (D)</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-52-2959-T</b>	
17. INFORMANT <b>Mamie Miles, Aberdeen, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>Chry. heart failure</b> <b>260X</b> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes mellitus</b> DUE TO (c) <b>years.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 18 1967</b> to <b>Nov. 15 1967</b> that (I) (we) last saw the deceased alive on <b>Nov. 15 1967</b> , and that death occurred at <b>2:20 PM</b> , from causes and on the date stated above					
22a. SIGNATURE <b>I, Mezei</b>		22b. DATE SIGNED <b>15 Nov. 1967</b>		22c. PHYSICIAN'S NAME (Type) <b>I, Mezei</b>	
22d. ADDRESS <b>Havre de Grace, Maryland</b>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>18 Nov. 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Presbyterian Cem.</b>	
23d. LOCATION (City or Town) <b>Darlington, Maryland</b>		(County)		(State)	
24. FUNERAL DIRECTOR <b>Tarring Funeral Home, Aberdeen, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 20 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas Judge</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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## CERTIFICATE OF DEATH

15467

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchville, R.R. 1, Box 90</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>12-1</u>	
3. NAME OF DECEASED (Type or print) First <u>Zollie</u> Middle <u>Greer</u> Last <u>Thompson</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>28</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/21/80</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>N. Carolina (Grassy Creek)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Greer (D)</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Pierce (D)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-07-3003</u>	
17. INFORMANT <u>Thelma T. Greenfield, Churchville, MD</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerosis (V. Disease)</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 7, 19 67</u> to <u>Nov. 28, 19 67</u> , that (I) (we) last saw the deceased alive on <u>Nov 28, 19 67</u> , and that death occurred at <u>1:13 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>J. Ralph Horky</u>		22b. DATE SIGNED <u>2/05/29 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horky, M.D.</u>		22d. ADDRESS <u>Churchville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1 Dec., 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Smith Chapel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Churchville, Maryland</u>	
24. FUNERAL DIRECTOR <u>Helton Macomber Jr</u>		25a. REC'D BY REGISTRAR <u>DEC 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 2-PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 20 Film 395 12-1-67 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15469

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15468

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN lb <b>25 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Bel Air</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Memorial Hospital</b>		d. STREET ADDRESS <b>Grafton Shop Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Isadora</b> Last <b>Treadwell</b>		4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 28, 1880</b>
9a. AGE (In years last birthday) yrs. <b>87</b>		9b. IF UNDER 1 YEAR Months <b>8</b> Days <b>12</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>	11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Poole</b>	
14. MOTHER'S MAIDEN NAME <b>Louisa Heusler</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>218-52-3478</b>		17. INFORMANT (Son) <b>838-4058</b> <b>Mr. R. Poole Treadwell</b> Address <b>P.O. Box #266 Bel Air, Md. 21014</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture Femur</b> DUE TO <b>9047</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic &amp; V Disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>-</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>10-27</b> 19 <b>67</b> p.m. <b>10-27</b> 19 <b>67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Harf. Conv. Home</b>	20f. (City or town) (County) (State) <b>Bel Air Harford Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Gerald C. Palmer</b> EXAMINER'S NAME (Type) <b>Gerald C. Palmer, M.D. Bel Air, Md.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Bel Air Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 22, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cath. Ch. Cem. Hickory, Harf. Co., Md.</b>
24. FUNERAL DIRECTOR <b>Joseph William Foster</b> <b>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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CERTIFICATE OF DEATH

15469

15470

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>1/10/t0/11/27/67</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Citizens Nursing Home</u>		d. STREET ADDRESS <u>24 Penna. Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>T.</u> Last <u>Turner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>27</u> Year <u>19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/21/81</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Harford County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thorn</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-54-0039</u>	
17. INFORMANT (See) <u>838-6406</u> <u>Mr. Robert N. Turner</u>		Address <u>24 Pennsylvania Ave. Bel Air, Maryland 21014</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>A-S-E-V-P</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rheumatoid arthritis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1</u> , 19 <u>67</u> , to <u>11-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-26</u> , 19 <u>67</u> , and that death occurred at <u>11-26</u> , 19 <u>67</u> , M, from causes and on the date stated above.			
22a. SIGNATURE <u>John D. Yoon</u>		22b. DATE SIGNED <u>Nov. 27, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN D. YOON</u>		22d. ADDRESS <u>HAVRE DE GRACE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 29, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cath. Ch. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Long Green, Balto. Co., Md.</u>
24. FUNERAL DIRECTOR <u>Joseph William Foster</u>		25a. REC'D BY REGISTRAR <u>NOV 29 1967</u>	
ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

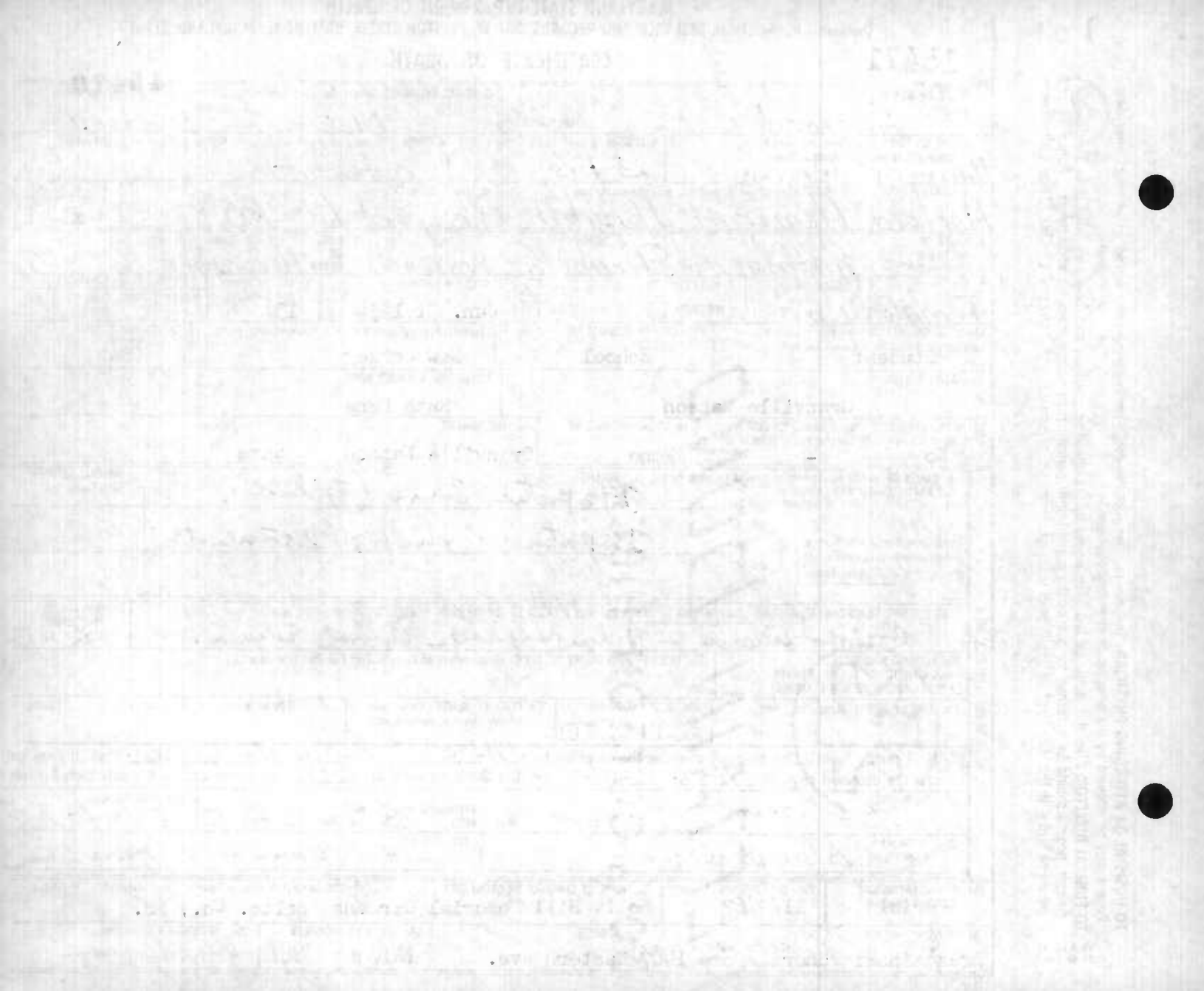


## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. LENGTH OF STAY IN 1b <u>13 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. STREET ADDRESS <u>Prospect Rd - RO 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Kathleen</u> Middle <u>Elizabeth</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>November</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31 1954</u>
9. AGE (In years last birthday) <u>13</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Granville Watson</u>	
14. MOTHER'S MAIDEN NAME <u>Ruth Lang</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Granville Watson</u> Address <u>Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Coma (Failure).</u> DUE TO (b) <u>Hepatic cirrhosis (Post neotenic).</u> DUE TO (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypoproteinemia - Splenomegaly - Cerebral Edema.</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-5</u> , 19 <u>67</u> , to <u>11-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-6</u> , 19 <u>67</u> , and that death occurred at <u>3:30AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Alonso Gomez</u>		22b. DATE SIGNED <u>11/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alonso Gomez</u>		22d. ADDRESS <u>419 S. Union Ave. Harre de Grace</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/9/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holly Hill Memorial Gardens Balto. Co., Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Bruzdzinski Funeral Home</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

15472

15471

1. PLACE OF DEATH a. COUNTY <u>Harford</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>INA</u>		4. DATE OF DEATH Month <u>June</u> Day <u>West</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10 1905</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u>	
14. MOTHER'S MAIDEN NAME <u>?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT <u>Lois M. Blackburn</u> Address <u>541 Bonnie Drive Aberdeen, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) <u>Hypertensive - Arteriosclerotic Heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 15</u> , 19 <u>67</u> , to <u>Nov 19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Nov. 19</u> 19 <u>67</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>George T. Stansbury</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>George T. Stansbury</u>		22b. DATE SIGNED <u>11/20/67</u>
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>	22d. ADDRESS <u>569 Revolution St. Havre de Grace, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>11/25/67</u>	23b. DATE THEREOF <u>Unk</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Unk</u>	23d. LOCATION (City or town) (County) (State) <u>Unk</u>
24. FUNERAL DIRECTOR <u>Prosser &amp; Son, Havre de Grace, Md.</u>	25a. REC'D BY REGISTRAR DATE <u>NOV 22 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			



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RECEIVED BY MAIL

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doit Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MIFFLIN H WILDE</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 8/1897</u>	
9. AGE (In years lost birthdays) <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>MARTINSBURG, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Rodger Wild</u>				14. MOTHER'S MAIDEN NAME <u>ANN ETTA Hedges</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES WWII</u>		16. SOCIAL SECURITY NO. <u>UNK</u>		17. INFORMANT <u>MARTINSBURG W VA</u> <u>JULIAN WILDE 1404 W. King ST</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V. Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel A: S: M</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> 11/15				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-15-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>11/16/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>MARTINSBURG W. Va.</u>	
24. FUNERAL DIRECTOR <u>Cennurhan Sam Hamed Shuaib</u>				25. REC'D BY REGISTRAR DATE <u>NOV 22 1967</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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STATE OF NEW YORK

In SENATE,  
January 15, 1912.

REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION  
PASSED BY THE SENATE  
JANUARY 10, 1911.

ALBANY:  
J.B. LEECH, STATE PRINTER,  
1912.

Price, 50 CENTS.

STATE OF NEW YORK